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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Malden "Rural"
(c) Name of hospital or institution: Home Care Hill Burg
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin
(c) City or town Malden "Rural"
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME OMA May Belt

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex female 5. Color or race W
6. (a) Single, widowed, married divorced 1
6. (b) Name of husband or wife Wm. Belt 6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased Sept 8 1908
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
34 1 19 hr. min.

9. Birthplace Dunklin County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name John W. Snider
13. Birthplace _____ Missouri (State or foreign country)
14. Maiden name Element Jones
15. Birthplace _____ Missouri (State or foreign country)

16. (a) Informant Wm. Belt
(b) Address Malden, Mo. R. 2

17. (a) Burial (b) Date thereof Oct 28, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director Lander Funeral Home
(b) Address Campbell, Mrs.

19. (a) 10-27-42 (b) W. Elder
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27
year 1942 hour _____ minute 8:00 A.M.

21. I hereby certify that I attended the deceased from October 6 1942 to October 27 1942
that I last saw him alive on October 27 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Uraemic poisoning complicating Chronic Luth
Due to _____

Due to 1486
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

Duration 3Wks
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(c) Means of injury fall
23. Signature Home Beall M.D. (Other)
Address Malden Mo Date signed 10-27-42

1288

RECEIVED

District Health Office No. 2,

District File Number 1142-1387

Date Filed 11-4-42

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.